



Municipality Insurance Enrollment and Change Form (FORM -1MUN)

01 <input type="checkbox"/>		Insured's GIC-ID (usually Soc. Sec. #) ____		Sex: Male <input type="checkbox"/> Female <input type="checkbox"/>		Date of Birth ____/____/____		Dept. ID # or Agency/Division # 666/														
Name - Last		First		MI																		
Address _____ <input type="checkbox"/> This is a new address				City _____		State _____		Zip Code _____														
Date Entered Service ____/____/____		City or Town employed or retired from _____				Home Phone (____) _____		Work Phone (____) _____														
02 <input type="checkbox"/> HEALTH COVERAGE								Effective Date: ____/01/____														
New Enrollment <input type="checkbox"/>		Change <input type="checkbox"/>		Cancel Coverage <input type="checkbox"/>																		
<input type="checkbox"/> Health (Select one of the health plans below and individual or family coverage)																						
<div>Health Plan – Active Employees and Non-Medicare Retirees</div> <table border="1"><tr><td><input type="checkbox"/> Fallon Direct</td><td><input type="checkbox"/> Navigator by Tufts Health Plan</td><td><input type="checkbox"/> UniCare/Community Choice</td><td rowspan="4">Coverage <input type="checkbox"/> Individual <input type="checkbox"/> Family</td></tr><tr><td><input type="checkbox"/> Fallon Select</td><td><input type="checkbox"/> NHP Care – Neighborhood Health Plan (HMO app required)</td><td><input type="checkbox"/> UniCare/PLUS</td></tr><tr><td><input type="checkbox"/> Harvard Pilgrim Independence</td><td><input type="checkbox"/> UniCare State Indemnity/Basic</td><td></td></tr><tr><td><input type="checkbox"/> Health New England</td><td>CIC: <input type="checkbox"/> Yes <input type="checkbox"/> No</td><td></td></tr></table>										<input type="checkbox"/> Fallon Direct	<input type="checkbox"/> Navigator by Tufts Health Plan	<input type="checkbox"/> UniCare/Community Choice	Coverage <input type="checkbox"/> Individual <input type="checkbox"/> Family	<input type="checkbox"/> Fallon Select	<input type="checkbox"/> NHP Care – Neighborhood Health Plan (HMO app required)	<input type="checkbox"/> UniCare/PLUS	<input type="checkbox"/> Harvard Pilgrim Independence	<input type="checkbox"/> UniCare State Indemnity/Basic		<input type="checkbox"/> Health New England	CIC: <input type="checkbox"/> Yes <input type="checkbox"/> No	
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03 <input type="checkbox"/> Name Change		Previous Name _____				New Name _____																
INSURED CHANGES								FOR GIC USE ONLY: Effective Date: ____/01/____														
06 <input type="checkbox"/> Retirement		Date Retired ____/____/____																				
07 <input type="checkbox"/> Transfer to another Agency		Name of Agency Transferred to _____						Effective Date ____/____/____														
08 <input type="checkbox"/> Transfer from another Agency		Previous Agency _____						Effective Date ____/____/____														
09 <input type="checkbox"/> Termination Coverage (if elected)		Termination Reason _____ Termination Date ____/____/____																				
<input type="checkbox"/> 39 -Week Layoff Coverage		<input type="checkbox"/> Deferred Retiree		<input type="checkbox"/> COBRA (must complete COBRA application)		<input type="checkbox"/> Conversion (contact carrier for application)																
SIGNATURE REQUIRED	Deduction Authorization I authorize my employer, or direct my pension authority, to deduct from my payroll or pension check the amount required for the coverage I have selected.																					
	At Retirement I hereby certify that I have filed an application for retirement and desire to continue my present coverage as a retiree. I also understand that if I am Medicare eligible, I am required to join one of the Group Insurance Commission's Medicare supplemental health plans to continue health coverage.																					
	Termination I understand that by electing to continue coverage under COBRA or Conversion, I must complete and return the corresponding application in order for this coverage to go into effect.																					
	• If you are applying for Health Insurance, be sure to file a Form IDF to list family members • If you are enrolling in an HMO that requires a separate application, be sure to file an application with the Plan.																					
	x _____ Signature of Applicant		Date _____		x _____ Signature of Authorized Official		Date _____															
FOR GIC USE ONLY:		Entered		Verified		Political Subdivision																

